

STI/HIV Testing: History Form

Name _____ Date _____ Age _____ DOB _____

Reason for our visit _____

I would like to be tested for _____

Do you think you have been exposed to an STD (sexually transmitted disease)? Yes No Unsure
If yes, please explain _____

List any chronic medical problems _____

List any **allergies** you have including medications or latex _____

List all medications you are now taking _____

Please answer the following questions so that we can best evaluate your needs.

Do your sexual practices include (check all that apply)? Oral sex Vaginal sex Anal sex

Have you had more than one partner in the past year? Yes No

Is your partner(s) Male Female Both?

Has your partner had sex with men? Yes No Unsure

Has your partner had partners other than you in the past year? Yes No Unsure

Have you or your partner had sex with anyone from CA, HI, Europe, Middle East, Asia, or the Pacific?

Yes No Unsure

Do you or your partner(s) use needles to take drugs? Yes No Unsure

Have you or your partner(s) ever had sex for money or drugs? Yes No Unsure

Have you received immunization (shots) against Hepatitis B? Yes No

Have a tattoo or body piercing? Yes No

Do you or your partner(s) use condoms for: (check all that apply):

	Always/Mostly	Never/Rarely	N/A
Vaginal Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anal Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had?

	Yes	No		Yes	No
--	------------	-----------	--	------------	-----------

Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	Genital Warts	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Not sure	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Other:		

FOR WOMEN:

When was the first day of you last menstrual period? _____ **Was it normal for you?** Yes No

Are you using a birth control method? Yes No If yes, what? _____

Are you experiencing an unusual vaginal discharge? Yes No

Do you have or have you had any sores or bumps? Yes No

Do you bleed after intercourse? Yes No

Do you have any other symptoms? _____

FOR MEN:

Do you have or have you had any sores or bumps? Yes No

Does it burn when you urinate? Yes No

Do you have any discharge from your penis? Yes No

Do you have any other symptoms? _____

To the best of my knowledge, the information on this form is complete and correct.

Client Signature: _____

Reviewed by: _____